BOSTON UNIVERSITY

SCHOOL OF RELIGIOUS AND SOCIAL WORK

Division of Social Work

THE THERAPEUTIC EMPHASIS IN FAMILY CARE AND ITS EFFECT ON THE FUNCTION OF THE SOCIAL WORKER

A Further Study

Of Family Care And Related Problems Based On Referrals To The Social Service Department of The Worcester State Hospital From 1937 To 1939

A Thesis

Submitted by:

Albert Mayor Stein

(B.S. Boston University, 1937)

in partial fulfillment of requirements for the degree of Master of Science in Social Service

1939

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INTRODUCTION

The following statement about family care was made by Dr. William A. Bryan, Superintendent of the Worcester State Hospital, in his Annual Report for 1936: "The family care program of the hospital has been increased during the year. After considerable experience with a large number of patients in boarding homes, I am more impressed than ever by the possibilities for a continuation and extension of this particular method of handling individual patients."[1]

This optimistic note was echoed through specific action. In 1937 a physician was appointed to devote almost his full time to family care patients. In 1938 a second social worker was added to the family care staff as a step in the attempt to stimulate and extend the growth of the system of family care for convalescing patients under commitment to the Worcester State Hospital.

In view of this expression of confidence in the possibilities of extending this method of care, both through word and action, it has been deemed necessary to study further the actual processes, significant factors and trends which make for the effective operation of this system.

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1. Worcester State Hospital Annual Report, 1936.

INTRODUCTION

This study will be an attempt to view the facts which need to be considered in the light of the extension of program, and to outline, if possible, more clearly the foci for growth and change indicated by such a program.

The study is based upon an analysis of all referrals and placements made during a two year period together with a discussion of related problems as they presented themselves and were dealt with by the family care social worker and physician. Special emphasis will be placed on an evaluation of the function of the social worker who has guided and supervised the operation of family care for over twenty years.

One hundred and sixty-eight patients were referred for placement at the regular staff conferences between January 1, 1937 and January 1, 1939; of this number there were one hundred and four patients involved in one hundred and ninety-four placements during this period. The records of these referrals and placements were studied and analysed statistically; also each patient was discussed with the referring doctors (if still on the staff) and with the family care social workers. The analysis of the function of the social worker, as viewed by the administrator, staff psychiatrist and social worker, was based on numerous consultations with those in position to offer their particular points of view.

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HISTORY OF FAMILY CARE AT THE WORCESTER STATE HOSPITAL

Just one hundred and five years ago the "Worcester Lunatic Asylum" was opened, the first state institution in Massachusetts for the care of the mentally ill. While the next few decades showed an increase in the number and size of institutions, by the year 1860 it had become evident that a building program large enough to meet the growing need would mean a great burden of taxation. Those interested in the problem began to look about for some other solution, and methods in use in other places were studied. It was discovered that a number of countries had cared for the mentally ill in private homes at a great saving to the state.

Dr. Samuel G. Howe, the first patron of the family care idea in Massachusetts, based his plan for a system of care upon his study of the Scotch and Belgian systems.[1] The study revealed the Belgian system as one characterized by the attempt of a whole community to devote itself to the care and attempted cure of mentally ill patients. In the Gheel colony, there were and still are hamlets where 95 per cent of the homes house at least one patient. When family care was first contemplated in Massachusetts and considered

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1. Loeser, Helen: Some Aspects of the Family Care Plan for Mental Patients at the Worcester State Hospital, Simmons College, 1934.

as a solution to the overcrowded condition at Worcester, the Gheel system was not considered adaptable for use. Some of the reasons given are as follows: It was felt that if too large a percentage of the population of any one community were mentally ill much of the value of the family care to the patient would be lost; it was argued that the people of Gheel had become a race of keepers without further interest, and that this led to a diminution of interests on the part of the patients placed with them; it was also stated that in order to avoid the evils of congregation the Gheel system ran into the opposite evil of too much individualism.

The plan favored by Dr. Howe in his report for the Board of Charities in 1867 was one similar to that operating in Scotland. His reasons were based partly on his admiration of the Scotchman's thrift and belief that his methods would net the greatest financial savings, and on the fact that it offered a number of advantages over systems of other countries; since never more than four patients - and usually only one - were placed in a home, and since these homes were scattered over every part of Scotland, the insane never made up too large a part of any one community and they profited by all the advantages of individualization. Patients under this system were given adequate supervision, each patient being visited once per year by a medical man and twice each year by the "social worker" - the overseer of the poor.

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The objections in Massachusetts to a plan of placement in private homes delayed its adoption as law for almost twenty years. Some of the reasons for the objections are listed as follows: the effect on the community was considered, and it was feared that those residing in rural communities with few diversions might take on the peculiarities of the patients they cared for; also the danger of neglect on the part of caretakers was pointed out in connection with the practical consideration that for the mere pittance paid for this care one could only expect to get poor homes with inadequate facilities. Most of the objections came from medical men who were primarily concerned with this problem. For instance, in 1884 Dr. Quinby, Superintendent of the Worcester State Hospital, objected to the plan "because the patients suited for such a plan are the ones whom the hospital could not be spared of, for they contribute largely toward re-imbursing the state for their support by the labor they perform."[1] But by the following year an act of the Massachusetts legislature provided for the boarding out of insane persons in private families by the Board of Health, Lunacy and Charities.[2] During the first twenty years after the law was passed, patients from various hospitals were chosen for family care by a representative of the state

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1. Annual Report of the Board of Health, Lunacy and Charities, 1884.
2. Annual Report of the Board of Health, Lunacy and Charities, 1885.

department, and were supervised by doctors and visitors - who were usually trained nurses - from the department.

In 1905 individual hospitals obtained the right to place patients in addition to those placed by the department. Worcester proceeded to place patients in 1905 but no real interest was shown in the project until 1915; there is no record of the number and nature of the placements during this ten year period. In 1915 the first social worker was appointed to deal specifically with the family care placements in addition to her other duties. During this year sixty-four patients of whom forty-seven were still out at the end of the year were placed in family care.[1] Gradually this number declined until in 1921 only eleven were placed and the total remaining in family care at the end of the year was twenty-two. From then on up to 1931 there were less than ten placements each year and the average number of patients in family care at one time, between 1921 and 1931, was fifteen.[2] The explanation of this decline in interest may partially be traced through the various economic fluctuations which greatly determined the availability of family care homes. During the World War period up to 1921 the increased prices in view of the stationary low rate of board made it impossible to

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1. Annual Report of the State Board of Insanity of the Commonwealth of Massachusetts, 1915.
2. Annual Reports of the Massachusetts Commission on Mental Diseases of the Commonwealth of Massachusetts, 1920-1931.

take patients. Another reason for the decline may be traced to the fact "that with the coming of the social worker the doctors who had been supervising the cases began to lose active interest. New doctors who came to the hospital with no previous contact with family care had no idea of the possibilities of placing patients outside the hospital."[1] In view of the custodial character of the system, the social worker found it practically impossible to do any constructive social work with the patients.

THE NEW EMPHASIS

Up to 1931 it was the consensus among physicians and social workers that family care was a dead issue and that it could not be used as a constructive force. However there then evolved a new conception of the use of the boarding home. According to Helen Crockett, Head Social Worker at the Worcester State Hospital at that time, two factors made the use of family care desirable and possible:

> "(1) The financial depression began to make itself felt in the inability of many relatives to care for patients who were sufficiently recovered to be given a trial outside the hospital, and other arrangements had to be considered. (2) At about this time, the successful and constructive use of boarding homes in the readjustment of two young dementia-praecox patients led us to consider the possible uses of family care as a tool in social case work. Could not the same plan which freed a hospital bed by removing to a private home a

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1. Bentley, Helen: A Study of the Family Care System at the Worcester State Hospital, Simmons College, 1934.

> chronic patient for whom there was little hope for further recovery be used to help in the adjustment of a convalescent patient who was without family or friends or whose own home was unsuitable? If the idea is sound then the boarding home becomes, not a permanent residence, but a stepping-stone to mental health, independence and self-support."[1]

With these possibilities in mind the psychiatric staff began to refer patients for therapeutic rather than for custodial purposes. With this impetus family care as a system for providing for the needs of mentally ill patients expanded rapidly. A social worker was appointed in 1932, whose sole duty it was to find homes, place patients and supervise them in family care. In 1934 there were seventy-seven placements and an average of ninety-six patients in boarding homes all the time. That year Dr. Bryan, Superintendent, made the following statement in his annual report:

> "We have continued to stress the boarding out of patients. It should be pointed out that in any program of boarding out some attempt should be made to utilize these boarding homes as therapeutic agents, and not purely as custodial homes. There are two classes of patients that should be considered in any family care program. First, the convalescent patient who for one reason or another should not be sent directly from the hospital to his home. Such patients will frequently be benefited by a sojourn in a supervised situation for a period of several months. The boarding home is a transition between the rather rigid discipline of the hospital and the comparative freedom of one's own home. On the other

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1. Crockett, Helen: Boarding Homes as a Tool in Social Case Work with Mental Patients, Mental Hygiene, April, 1934.

> hand there are the group of custodial patients who are much better off in the environment of a home. During the year (1934) we have sent fifteen patients from boarding homes to their own homes and changed their status to that of visit. Seven have become self-supporting, having found positions."[1]

By 1935 the placements had exceeded one hundred patients and the annual report spoke in glowing terms:

> "The hospital is more impressed by the good results of the social method of treatment through family care than ever before. It is noted that 17 per cent of the total number of patients who were placed during the year were either discharged or their status changed to visit. Used as a social case work tool, family care adds a powerful weapon to the armamentarium of the psychiatrist."[2]

In spite of the sudden boom resulting in placements far exceeding all expectations, from 1936 on there has been a noted slowing down in the placement of patients, until by the middle of 1938 the statistical reports revealed a marked drop in referrals and placements. The reasons for such a change in trend may be traced to the economic recession and the realization that the burden of the one family care social worker was far too great in the light of her responsibilities and case load. A further attempt to analyse this trend with its causes will be made in Section IV.

The hospital administration's point of view toward the present and future of family care is reflected in excerpts

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1. Worcester State Hospital Annual Report, 1934.
2. Worcester State Hospital Annual Report, 1935.

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from a published statement by Dr. Bryan:

> "While the boarding-out plan of caring for mental patients does result in saving represented by diminished capital expenditure for new buildings, yet I believe the major potentialities lie in the therapeutic field. There are many patients in the state hospitals who are inmates apparently because of precipitating factors in their immediate environment, the home. We have usually found it necessary to return many patients who are convalescing satisfactorily directly back into an unhealthy situation. It has seemed to us much better practice to utilize our boarding homes as a first step toward complete emancipation from the hospital influence rather than return patients directly to what cannot help from being a most trying situation for the patient. We hope that this plan will eventually result in a lowering of the readmission rate ..... in brief, I thoroughly believe in the possibilities of this form of treatment for certain types of mental patients, providing adequate social service and medical supervision can be extended to the patient."[1]

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1. Pollock, Horatio: Family Care of Mental Patients, State Hospitals Press, Ithaca, New York, 1936.

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STATISTICAL ANALYSIS OF REFERRALS AND PLACEMENTS

A. CLASSIFICATION

An analysis by the present writer of the patients referred and placed reveals interesting changes and trends particularly according to psychosis and sex.

TABLE 1

REFERRALS AND PLACEMENTS ACCORDING TO PSYCHOSIS AND SEX
(1937 - 1939)

Psychosis	Referred				Placed			
	M.	F.	T.	P.C.	M.	F.	T.	P.C.
Dementia-Praecox	44	32	76	45%	21	21	42	40%
Senile and Cerebral Arteriosclerosis	7	15	22	13%	5	10	15	14%
Manic-Depressive	4	15	19	11%	3	11	14	13%
Alcoholic	10	2	12	7%	8	1	9	9%
Mental Deficient	2	4	6	4%	2	3	5	5%
Organic	7	2	9	5%	2	2	4	4%
Paranoid Conditions	2	6	8	5%	1	4	5	5%
Paresis	2	0	2	1%	1	0	1	1%
Psychoneurosis	2	3	5	3%	2	2	4	4%
Involutional Melancholia	2	5	7	5%	0	4	4	4%
Psychopathic Personality	0	2	2	1%	0	1	1	1%
Totals	82	86	168	100%	45	59	104	100%

It is noted in the 1934 study that over a three year period 46 men and 126 women were placed in family care.[1] There were 45 men and 59 women placed during this period studied (1937-1939), as indicated in Table I. The increase in the number of men placed, in proportion to women, may be explained by the greater availability of homes for men during this period, and because of the growth in the feeling, both on the part of the hospital and of the caretakers, that men are not too great a risk for this type of placement.

Table II reveals that nearly half of the referrals and placements were schizophrenic patients. This number far exceeds the percentage of schizophrenics admitted to the hospital and those still remaining in the hospital (residue).

TABLE II

COMPARISON WITH INTAKE AND RESIDUE[2]

Psychosis	Referrals		Placements		Intake		Residue	
	No.	P.C.	No.	P.C.	No.	P.C.	No.	P.C.
Dementia-Praecox	76	45%	42	40%	250	25%	136	26%
Senile and Cerebral Arteriosclerosis	22	13%	15	14%	295	19%	236	44%
Manic-Depressive	19	12%	14	13%	65	6%	26	5%
Alcoholic	12	7%	9	9%	71	7%	17	3%
Others	39	29%	24	24%	341	33%	119	22%
Totals	168	100%	104	100%	1022	100%	534	100%

1. Bentley, Ibid., page 19.
2. Worcester State Hospital Annual Reports, 1936-1937.

Also, an analysis of intake in Table III shows that 30 per cent of all schizophrenics admitted over a two year period were referred by the staff for family care placement, and 17 per cent of all the schizophrenics admitted were placed:

TABLE III

PERCENTAGE OF INTAKE REFERRED AND PLACED

Psychosis	Intake	Referrals		Placements	
		No.	P.C.	No.	P.C.
Dementia-Praecox	250	76	30%	42	17%
Senile and Cerebral Arteriosclerosis	295	22	8%	15	5%
Manic Depressive	65	19	29%	14	22%
Alcoholic	71	12	17%	9	13%
Others	241	39	11%	24	7%
Totals	1022	168	17%	104	10%

In view of the predominance of schizophrenics placed, a further analysis of the statistics was made. This shows that the male schizophrenics are still harder to place: 48 per cent of the male schizophrenics as compared with 66 per cent of the female schizophrenics referred were placed. The latter percentage compares more favorably with the percentage of placements of the other psychoses, as shown in Table IV.

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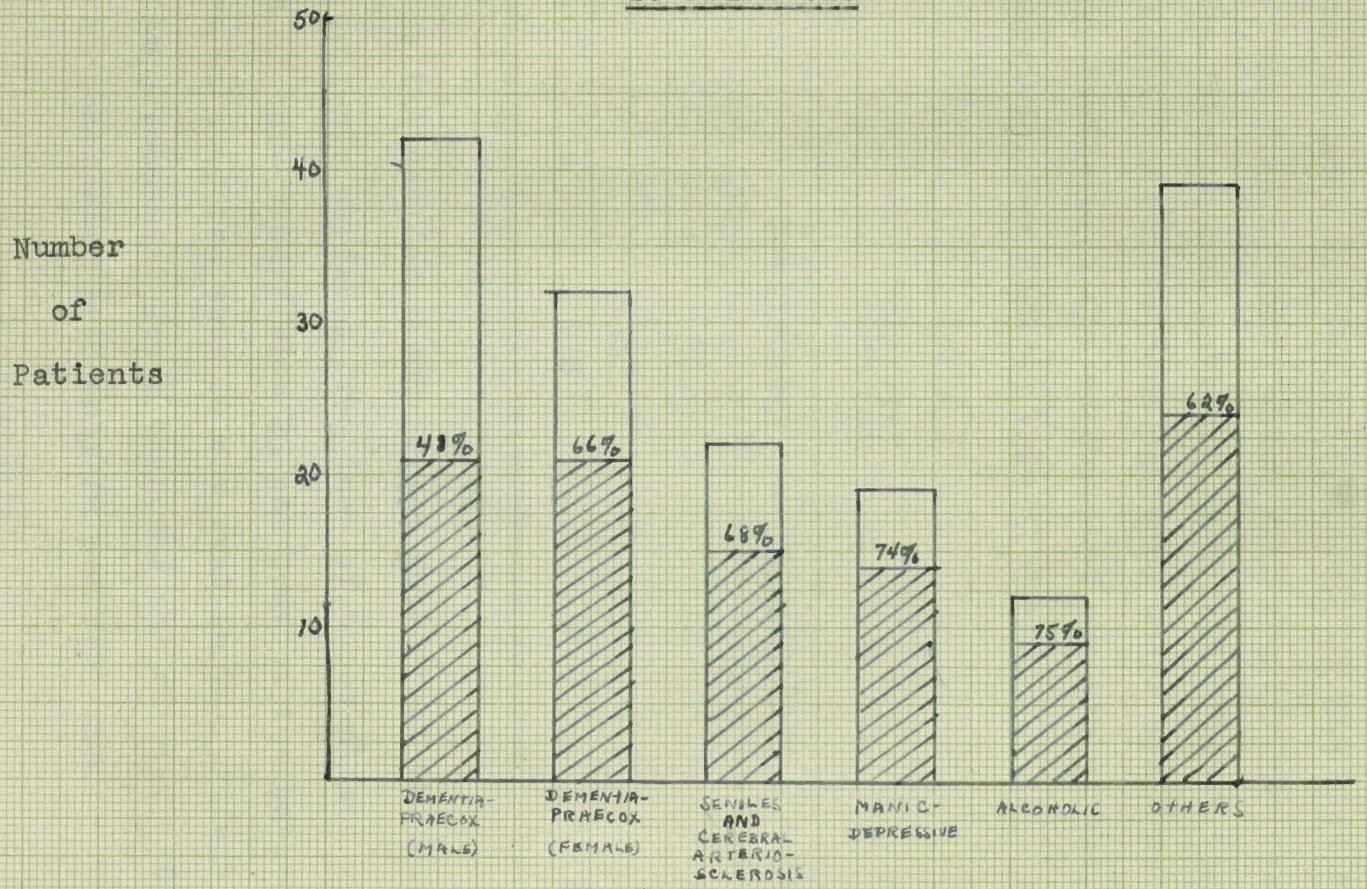
In view of the predominance of schizophrenics placed, a further analysis of the statistics was made. This shows that the male schizophrenics are still harder to place. 43 per cent of the male schizophrenics as compared with 66 per cent of the female schizophrenics referred were placed. The latter percentage compares more favorably with the percentage of placements of the other psychoses, as shown in Table IV.

TABLE IV

PERCENTAGE OF REFERRALS PLACED, ACCORDING TO PSYCHOSIS



Tables V, VI and VII show the referrals and placements according to nativity, marital status and religious groupings. These classifications reveal first that the foreign born are more difficult to place. It has been acknowledged that finding homes which will satisfy the cultural needs of the foreign born patients is more difficult than obtaining homes for native born patients where their needs fall in more easily with the established pattern of the ordinary American, New England type of home:

TABLE V

NATIVITY

	Native Born	Foreign Born	Total
Placed	86	18	104
Not Placed	44	20	64
Total	130	38	168

In the earlier study it was noted that the marital status of patients differed from that of those placed during the period of this study, with 23 per cent of the patients single then as compared with 60 per cent in the present study.[1] The predominant group then was the married, 58 per cent then as contrasted with only 20 per cent now.

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1. Bentley, Ibid., page 19.

TABLE VI

MARITAL STATUS

	Single	Married	Widowed or Divorced	Total
Placed	63	21	20	104
Not Placed	32	20	12	64
Total	95	41	32	168

TABLE VII

RELIGIOUS GROUPING

	Protestant	Catholic	Others	Total
Placed	42	59	3	104
Not Placed	20	43	1	64
Total	62	102	4	168

It is noted, in summary, that the trend has been toward the referral and placement of native born, single patients. The distribution, according to religious groupings is in proportion to that found normally in the hospital.

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B. TREND

It is generally assumed that one important factor in the success of the placement of the patient is the length of time the patient has been in the hospital prior to the placement. Table VIII shows referrals and placements according to length of commitment:

TABLE VIII

REFERRALS AND PLACEMENTS ACCORDING TO LENGTH OF COMMITMENT

	1-6 Months	6-12 Months	1-2 Years	2-5 Years	Over 5 Years	Total
Referred	40	22	33	25	48	168
Placed	28	14	24	14	24	104
(P.C. placed)	(70%)	(64%)	(73%)	(56%)	(50%)	(62%)

In the 1934 study it was found that 49 per cent of the patients placed had been in the hospital less than three years.[1] The present study shows that 63 per cent of the patients had been in the hospital less than two years, thus revealing that the trend has been toward selection of patients who have been under commitment for shorter periods.

Table IX shows referrals and placements according to age groups and indicates that 39 per cent of all the

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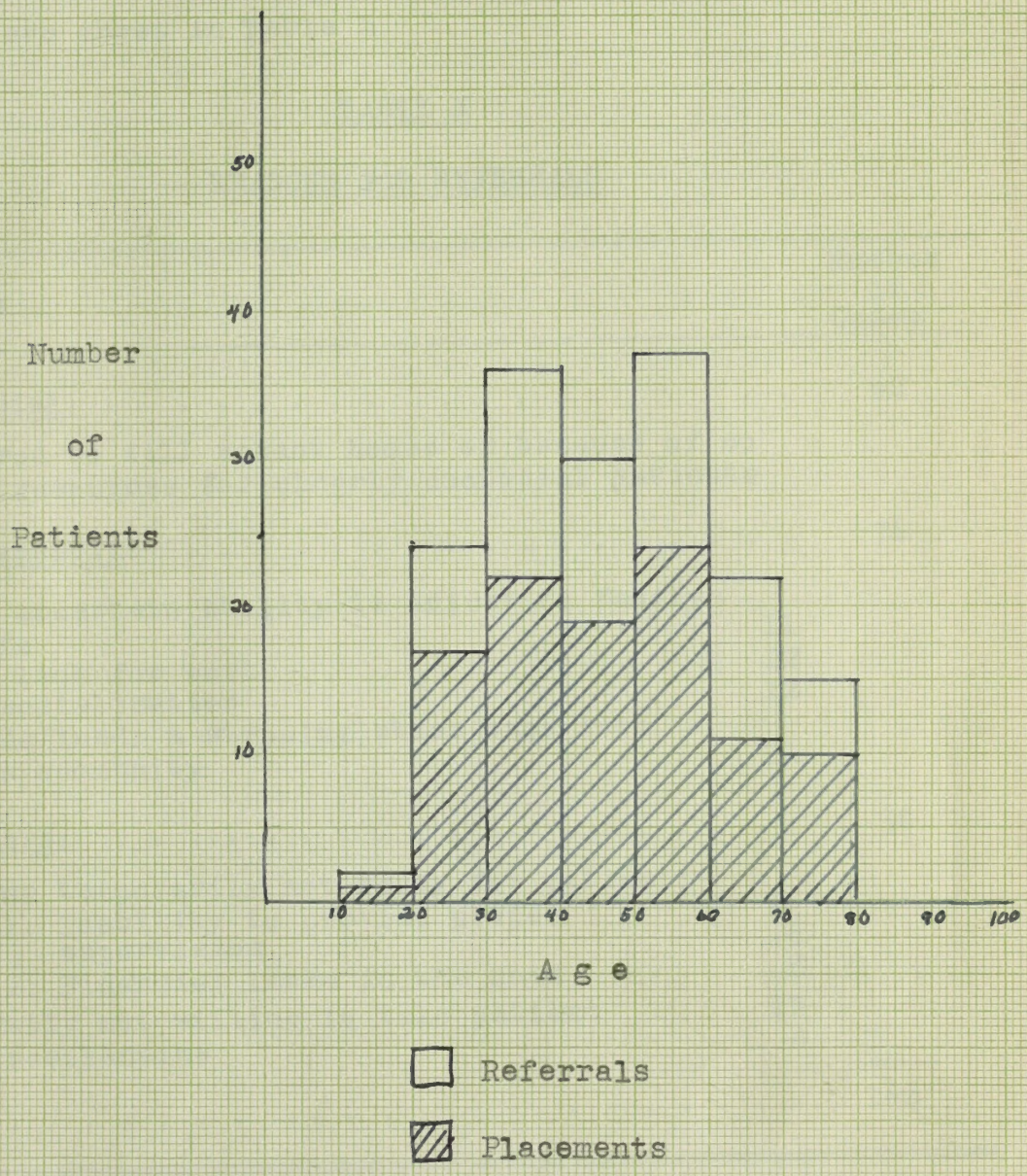
TABLE IX

REFERRALS AND PLACEMENTS ACCORDING TO AGE GROUPS



patients placed were under forty years of age, nearly doubling the percentage under forty as noted in the 1934 study.[1]

C. REASONS

The reasons for the referrals, as stated in the records, are shown in Table X.

TABLE X

REASONS FOR REFERRALS

Reasons		Number of Cases
I. Custodial:		62
Referred to fill vacant homes or because of no other resources for elderly custodial patients		
II. Therapeutic:		76
A. To ascertain ability to adjust to family life	11	
B. To look for work	22	
C. Resocialization	12	
D. Undefined: a stepping stone back into the community	31	
III. Others:		30
A. Home temporarily not ready for patient:		
1. Inability to provide proper supervision	6	
2. Financial lacks in the home	8	
B. Family not willing to take patient	12	
C. Miscellaneous	4	
Total		168

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2. Financial looks in the home	8
B. Family not willing to take patient	12
C. Miscellaneous	4
Total	153

1. Bentley, Ibid., page 30.

Of those referred for custodial care, 63 per cent were placed. Seventy per cent of those referred for treatment were placed and only 40 per cent of the others. It was of interest to note that the staff often specified special precautions and recommendations in addition to their statements of reasons for referrals. For example, special precautionary measures were indicated in twenty cases of suicidal patients, drug addicts and those liable to wander off. Particular advantages and opportunities were specified in eleven cases. Certain types of homes, social and cultural levels considered, and individual types of care were indicated in twelve cases.

Of the one hundred and sixty-eight patients referred, sixty-four, or 38 per cent, were not placed. The reasons as indicated in Table XI reveal that only in 14 cases, or 22 per cent of those not placed, were there no homes either available or suitable for the patients referred.

TABLE XI

REASONS WHY PATIENTS WERE NOT PLACED

Reasons	Number of Cases
Patient's condition got worse - plan dropped	14
Patient refused to go	12
No home suitable	10
Family took patient on visit prior to placement	8
Pending	8
No homes available for men patients	4
Change of plan by staff	4
Miscellaneous	4
Total	64

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Miscellaneous	4
Total	64

There is usually a period of one to four weeks between the referral and actual placement. During this period various changes in the condition of the patient may take place and one of the major reasons for not placing a patient has been the patient's sudden relapse necessitating the dropping of the family care plan. For many patients the proposed change of situation represents a threat to their security, especially if they have been in the hospital for some length of time. For this reason, as well as others, many of the patients at first refuse to consider going out in family care. It is noted that of the entire group referred, 27, or 16 per cent, at first refused to go. Fifteen of the objectors finally consented to go into family care homes following persuasion on the part of the social worker, the referring physician and in a few cases pressure by the superintendent. It is interesting to note that when family care was proposed by the staff as an alternative plan to the twelve families who were unwilling to take the patient home on visit, in 8 cases the family took the patient rather than permit such a placement.

D. ADJUSTMENT

It is difficult to evaluate the total adjustment especially when such evaluation must be primarily subjective. The sources for this evaluation are those who had contact

with the patients over the entire period of placement, viz. the psychiatrist and the social worker. Certain arbitrary criteria were established as a basis for the evaluation, and the informants were guided by them in every case. The three rating categories were: good, fair and poor. A good adjustment was one wherein: (1) the patient showed notable improvement in his physical and mental condition; (2) his placement was marked by a much better social adjustment, and as a result; (3) he had a good prognosis for going on visit or discharge. A fair adjustment was one in which the patient manifested his ability to make a better adjustment to family life, than in the hospital, but whose mental condition was the basis for occasional upsets necessitating either temporary return to the hospital or retention in the home with some difficulty. The groups which were found most frequently in this category were the female manic-depressives and the seniles. The poor adjustments included those patients who failed completely to make an adjustment in the family care home, and whose stay was characterized by frequent upsets, and various other problems as indicated in Table XIV. In almost every case this resulted in the return of the patient to the hospital within a short period following his poor adjustment.

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In discussing the adjustments, it is noted that statistically there is little of significance in the

comparison according to sex. Fifty-eight per cent of the males placed made good adjustments, very close to the figure of 54 per cent for the females placed. According to psychosis however, interesting data are found. Of the larger groups placed, the one making the best record of adjustment was the alcoholic with 78 per cent of the placements making good adjustments. It was observed that the alcoholics made a good initial adjustment but remained in family care somewhat longer than other groups. Among the larger groups the manic-depressives made the poorest adjustments - only 43 per cent of all placements. Among the smaller groups it was noted that the four psychoneurotics placed made poor adjustments as contrasted with all the organic psychotics who in each of the four cases placed made a good adjustment.

Tables XII and XIII analyse the adjustments according to psychosis, sex, and quality of the adjustments:

TABLE XII

ANALYSIS OF ADJUSTMENTS ACCORDING TO PSYCHOSIS AND SEX

Psychosis	Sex	ADJUSTMENTS Good	Fair	Poor	Total
Dementia-Praecox	M.	11	6	4	21
	F.	13	3	5	21
	T.	24	9	9	42
Senile and Cerebral Arteriosclerosis	M.	2	1	2	5
	F.	5	5	0	10
	T.	7	6	2	15
Manic-Depressive	M.	2	1	0	3
	F.	4	4	3	11
	T.	6	5	3	14
Alcoholic	M.	6	2	0	8
	F.	1	0	0	1
	T.	7	2	0	9
Mental Deficient	M.	1	1	0	2
	F.	3	0	0	3
	T.	4	1	0	5
Organic	M.	2	0	0	2
	F.	2	0	0	2
	T.	4	0	0	4
Paranid Condition	M.	1	2	1	4
	F.	1	0	0	1
	T.	2	2	1	5
Paresis	M.	1	0	0	1
	F.	0	0	0	0
	T.	1	0	0	1
Psychoneurosis	M.	0	0	2	2
	F.	0	0	2	2
	T.	0	0	4	4
Involutional Melancholia	M.	0	0	0	0
	F.	3	0	1	4
	T.	3	0	1	4
Psychopathic Personality	M.	0	0	0	0
	F.	0	0	1	1
	T.	0	0	1	1

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	F.	1	0	0	1
	T.	7	2	0	9
Mental Deficient	M.	1	1	0	2
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	F.	1	0	0	1
	T.	2	2	1	5
Paresis	M.	1	0	0	1
	F.	0	0	0	0
	T.	1	0	0	1
Psychoneurosis	M.	0	0	2	2
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	T.	0	0	2	2
Involutional Melancholia	M.	0	0	0	0
	F.	3	0	1	4
	T.	3	0	1	4
Psychopathic Personality	M.	0	0	0	0
	F.	0	0	1	1
	T.	0	0	1	1

TABLE XIII

"GOOD" ADJUSTMENTS ACCORDING TO PSYCHOSIS

Psychosis	Placements	Good Adjustments	P.C.
Dementia-Praecox	42	24	57%
Senile and Cerebral Arteriosclerosis	15	7	47%
Manic-Depressive	14	6	43%
Alcoholic	9	7	78%
Others	24	14	58%
Total	104	58	56%

E. PROBLEMS

As indicated in previous discussions many problems presented themselves during the period of placement. A number arose out of the mental condition of the patient and were difficult to deal with in the boarding home. With elderly patients - who were primarily custodial placements - physical ailments presented many difficulties. Where there were several patients in a home, and when they were constantly thrown together in joint activities, friction often resulted and sometimes reached such proportions that one or more of the patients had to be removed from the home. The routine activities of the home such as taking a bath, of

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keeping one's room in order and doing one's share of the work were sometimes avoided by the patient. It is in such situations as these that the caretaker's skill comes into play in stimulating the patient to accept his responsibilities. Often patients expressed great unhappiness during the first few days of placement, especially if they were among those who originally objected to such placement. Table XIV lists some of the problems which were found during placement:

TABLE XIV

PROBLEMS DURING PLACEMENT

Problems	Number of Cases
Periodic mental upset	23
Physical illness	9
Difficulties arising out of contacts with other patients in the home	9
Patient refused to carry out routine duties	6
Patient expressed unhappiness	5
Miscellaneous minor problems	15

The relationship between the problems shown and the eventual removal of the patient from family care seems worthy of investigation. All but one of the patients who presented problems due to their mental condition were eventually removed from their family care homes and returned to the hospital. In 45 cases, 58 per cent, the removals were

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of a temporary nature, later resulting in re-placements usually in the same homes from which they were taken after a brief stay in the hospital. In 8 cases patients were replaced twice within this two year period. Twenty-seven per cent of the removals were due to change of status directly from family care to visit or discharge.

Table XV outlines the reasons why patients were removed from their family care homes during this period studied:

TABLE XV

REASONS FOR REMOVAL FROM FAMILY CARE

Reasons for Removal	Number of Cases
Mental upset	22
To visit (directly from family care)	12
Discharged (directly from family care)	9
Walking away from home (escape)	9
Physical illness	5
Family care home given up	4
Inability to adjust to family life	17
Total	78

F. PRESENT STATUS

An accounting, on January 1, 1939, of all the patients placed during the period studied reveals the following, in Table XVI.

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PRESENT STATUS OF PATIENTS PLACED

Sex	No.	Family Care		Hospital		Visit		Discharged	
		No.	P.C.	No.	P.C.	No.	P.C.	No.	P.C.
Male	45	25	56%	11	24%	6	13%	3	7%
Female	59	27	46%	20	34%	6	10%	6	10%
Total	104	52	50%	31	30%	12	11%	9	9%

By January 1, 1939, 20 per cent of all the patients placed during the period studied had been discharged or released on visit. This figure compares favorably with similar reports covering the period since 1930.[1]

The present status of patients referred but not placed in family care reveals that 17, or 29 per cent, of those not placed are no longer in the hospital. Eight of the 17, however, went on visit rather than accept the family care plan. Thus we can partially credit to family care the provision of the stimulus which prompted the change to visit status.

G. VALUE

The value to the patients of the placements should be measured in terms of the objective of the placements. If

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the ultimate objective is to effect the return of the patient to status in the community, we find that but 19 per cent of the patients have been thus helped. We must consider, however, that a number of the patients, still in family care homes, have been helped to adjust more adequately to their mental symptoms, and may sooner or later be able to effect some kind of an adjustment in the community. Also, in a number of cases the morale of the patients has greatly improved, and there is apparent a definite wish to get well and return to their own communities.

Through interviews with the social worker and the physician it has been possible to determine - as shown in Table XVII - how the placements have been of value to a number of the patients. It many cases obviously a patient has been aided in more than one way and therefore is included more than once.

TABLE XVII

HOW PLACEMENT IS OF VALUE TO THE PATIENT

How of Value	Number of Cases
Physical condition improved	68
Mental condition showed marked improvement	38
Made better social adjustment than in hospital	23
Gave patient more security and self-confidence	20
Patient happier in family type of environment	18
Obtained work through placement	14
Marked evidence of resocialization	13
Instrumental in patients' release on visit	12
Instrumental in patients' discharge	9

The advantages of family care as seen and stated spontaneously by the patient are listed below:

1. Home life gives a feeling of being part of a family - a feeling of belonging.
2. The food is much better.
3. The noise of the hospital is avoided.
4. Contacts with normal people.
5. Ability to participate in community life on an equal and accepted level.
6. More freedom and independence -- a change from the routine of the hospital.
7. When looking for work one can give a home address rather than that of a mental hospital.

With regard to psychosis it is noted that in all but the manic-depressive patients more than half of the number seem to benefit to some extent from the placements. Table XVIII indicates the value according to psychosis:

TABLE XVIII

VALUE OF PLACEMENT ACCORDING TO PSYCHOSIS

Psychosis	Value	No Value
Dementia-Praecox	23	19
Senile and Cerebral Arteriosclerosis	8	7
Manic-Depressive	5	9
Alcoholic	6	3
Others	13	11
Total	55	49

This study gives some evidence that the family care home has much to offer to the patient in both his physical and mental rehabilitation.

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THE FUNCTION OF THE SOCIAL WORKER

The use of family care placements by the Worcester State Hospital antedated by ten years its supervision by social workers. At first the patients were supervised by the medical staff who investigated homes to determine their suitability. Since the purpose of the plan was to free hospital beds, save expense to the state, and at the same time give more freedom to the individual patient, much emphasis was placed on physical surroundings, blankets, space, food and clothing. Patients were not to be exploited, overworked or abused in any way. The dissatisfied patients were replaced or returned to the hospital. With the coming of the first social worker in 1915, the tasks of supervision and investigation were soon assigned to her and the number of visits from the physicians dwindled to almost none.

The function of the social worker in relation to family care during the early years of its existence involved routine investigations and visitations to homes boarding the small number of custodial patients. The contacts were not frequent and were primarily for the purpose of rendering personal services as required by the physical needs of the elderly patients. Primarily because of the purpose of the placement and the great difficulty in securing homes the need for careful selection in finding homes was not viewed

THE FUNCTION OF THE SOCIAL WORKER

as of much importance until the therapeutic emphasis became prevalent.

The new therapeutic emphasis has required greater care in the selection of homes. This has eliminated, as the primary ones, the old material considerations of shelter and clothing, and placed special emphasis on the needs of the patient in relation to the atmosphere of the home and the personality and skills of the caretaker. There is also the added responsibility of understanding the personality and needs of the patient as a basis for placing him, carrying on a therapeutic supervisory relationship, and the guidance of the caretaker toward more therapeutic effectiveness. One can thus see that this growth has increased the responsibilities and tasks of the family care social worker.

Statistics show that the family care placements have increased ten-fold since 1931 and with this increase has come an integration of the social worker's functions.[1] In spite of such an integration the social worker's task grew so rapidly and reached such proportions that an increase in personnel has been indicated as necessary since 1934 when the clinical director made reference to such a need in his annual report:

> "It is obvious that with the large number of patients out of the hospital that more than one social service worker is needed. This department should be supervised by one psychiatrist and two social workers."[2]

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1. Worcester State Hospital Annual Reports, 1931-1937.
2. Worcester State Hospital Annual Report, 1934.

In the 1935 Annual Report the head of the Social Service Department made the following statement:

> "Since the depression our applications from families who wish to board out patients have increased. The number of such requests which come in from homes of poorer type has risen, bringing, as result, the need for more careful investigation to insure the welfare, mental as well as physical, of out patients. This has increased the burden of the social worker in charge of family care, and if continued may result in one of two things -- either fewer patients in family care, or lessened investigations and consequently poorer homes. It may be that in the future it will be found expedient to divide the work of this particular part of the social service department, delegating to one worker the investigation of applications for boarding homes and to another the supervision and treatment of the patients involved. If we are to consider our boarding homes as of definite psychotherapeutic value in the treatment of out patients, intensive investigation and supervision is essential."[1]

However, the one family care social worker was left to carry the burden until 1937. In that year the hospital was granted a special worker for a period of three months for an intensive study of family care. In the Annual Report of 1937 an explanation is given why this second social worker was not re-appointed:

> "Many applications were investigated in an attempt to find more boarding homes, thus enabling us to place more patients on this basis. It was found that because of the rise in food prices, it was extremely difficult to find families willing to accept patients for the $4.50 per week paid by the state for boarding patients. Several homes

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1. Worcester State Hospital Annual Report, 1935.

> were found which would take patients at $7.00 per week and up, but for the same economic reason few of our families felt themselves able to pay even that sum for their relatives. Consequently, we were unable to place the number of patients deemed essential for the maintenance of two workers on family care, and when her second appointment for three months was concluded she was not re-appointed."[1]

With the continued encouragement for extension of family care emanating from the administration, a social worker was appointed in September, 1938, to work in the family care department. This provisional appointment is to be in effect for one year, and if the development of the work warrants it, the position will be made permanent. It is interesting to note that up to January 1, 1939, four months after the date of this appointment, the number of homes available for use and the number of patients placed have increased 25 per cent.

With the specific functions of the social worker still indefinite in their scope, it should prove of value to paint a picture of the actual activities of the social worker, in an attempt to gain some insight into that which comprises her daily work.

A. THE REFERRAL

The family care social worker first enters the case at the Social Service-Staff conference. Here a statement of

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1. Worcester State Hospital Annual Report, 1937.

the reasons for referral and a general discussion of the needs of the patient are initiated by the referring physician. The worker then acquaints herself with the patient's record, with special attention given to the reports of behavior and social adjustment in the hospital, and the history of home adjustments prior to commitment. There follows a consultation with the clinical director and the referring physician wherein the specific reasons for placement, both social and psychiatric, are discussed. The type of home and supervision required are indicated.

The initial contact with the patient is the next step. The purpose of this first interview, usually held on the ward, is to establish rapport, explain the nature and objectives of family care, and to permit the patient to discuss the type of home he would prefer. This is sometimes the first knowledge by the patient of his proposed placement and involves tact and skill on the part of the worker to "sell the idea." Often a number of interviews are necessary before the patient will consent to such a plan, and this is one factor in the lapse of time between the referral and actual placement.

Before the patient can be placed, the relatives and guardian (if there is one) must be interviewed or consulted through the mail in regard to their feelings about placement. Such practical problems are discussed as their

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ability to pay for the patient's room and board, the location of the family care home, and the visiting arrangements. It is at this time that the social worker paves the way for the patient's later return to the community. The interviews with the relatives may include an interpretation of the patient's illness, a discussion of the family's feelings about this illness, and its responsibilities to the patient.

After all preliminary arrangements are made, and if a home is available and suitable, the patient is placed. Homes are usually available and ready for use. This is possible because the social worker is constantly investigating and certifying new homes for use, even when no particular patient is being considered for placement. Occasionally new homes must be obtained.

B. FINDING THE HOME

The definite standards which are the basis for the selection of the home are determined primarily by the needs of the patients. The points of emphasis in this selective process are: the locality of the home, its physical structure and surroundings, the economic status of the family, and the qualifications of the applicant-caretaker.

Locality was re-emphasized as a factor in 1933 when the Department of Mental Hygiene assigned six homes and ten patients to the Worcester State Hospital for supervision.

These homes are 45 miles from the hospital in the town of Tewksbury and are too difficult to reach for adequate social service supervision. As a result the homes have been used exclusively for custodial purposes; for patients requiring close supervision and treatment these homes are too far from the hospital. There is also a need for proximity to church and to urban centers for patients needing opportunity to look for work and for those patients wishing to make use of educational facilities.

In considering the physical structure of the home, facilities for recreational and occupational activities are required. Sanitation is stressed; only modern toilet accommodations are held acceptable. There must be single beds for each of the patients and no overcrowding in the rooms.

The economic status of the home has always been a major consideration. In a number of cases, however, the money paid for the care of the patients is the only income, but in these cases there always are other assets in the home which make such a selection advisable. Financial difficulties do not disqualify a home for use, but worry, fear of losing the home, and financial insecurity great enough to absorb the family's interest and attention react unfavorably on the patient. This is so, not necessarily because the family exploits the patient, but because "the patient shares the sorrows and worries as well as the joys of the family during

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his close association with them."[1]

Special training or nursing experience is not necessary to qualify as a caretaker. In some cases, in which it leads to too much self-satisfaction, it is a liability. The best caretakers are those who are challenged by the problems of mental illness and wish to make some contribution to their solution. The caretaker must first manifest a sincere interest and willingness to face the problems involved in such care. Also she must be a person of ingenuity, able to find tasks suited to each member of the family of patients, in order that they may feel that they are contributing to the common good.

Home finding was a problem for the social worker in the early days of family care. In the beginning, a few of the homes were obtained through the local child-placing agency, but these did not prove satisfactory for the mental patient with his idiosyncrasies did not make the same appeal as did the little child. The method which proved successful was that of advertising in those communities to which the regular social worker's duties carried her. Newspapers in the city, the county and in surrounding smaller communities were used. Many relatives, appreciative of what the hospital was doing for their own patients, went out of their way to advertise the need of homes. The social worker found the

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1. Crockett: Ibid., page 198.

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appointment is very often made so that all the members of the household will be at home. The first question to be answered is why the family wishes to board patients; in most cases this has been due to the desire to supplement their income. The experience and qualifications for caring for patients are discussed; many homes have had state children and no longer wish to care for them. The caretaker's plans for occupational and recreational activities for the patients are outlined. After the inspection of the homes has been completed, the worker usually is aware of the possibilities of the home and the qualifications of the caretaker. At this point she either decides to reject the home and conclude the investigation, or to accept it tentatively as a possibility and continue the interview by outlining the exact nature and requirements of the family care plan. The worker then discusses mental illness, the types of patients placed and the needs of convalescing patients. The responsibilities of the caretaker are outlined and amplified by the reading of the form list of instructions. The changes in the physical set-up of the home which are needed to meet the requirements for placement are explained. The family is informed that these changes must be made before patients can be placed, but they are cautioned not to make them until the home is officially accepted.

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contacted either personally by the social worker or through a form letter. Others contacted are those who the worker knows are sources of information about the family being investigated. When the social worker makes her final decision to accept the home a form letter is written to the caretaker informing her that the home is certified for use, thus permitting her to complete any changes which must precede the placement. A second visit is made to the home by the social worker to see if these changes have been made and to discuss the patient who is to be placed with the family. The personality, eccentricities and habits of the patient are talked over with the family, and thus it is prepared with information on what precautions and emergency measures to use.

C. FITTING THE PATIENT TO THE HOME

Miss Crockett, in discussing this point in her paper, referred to it as "the most important step in social treatment."[1] She pointed out that the finding of the right kind of situation for each patient at the outset if possible, not only saves the social worker's time, but also avoids discouragement on the part of the patient. She illustrates this point by giving examples of a number of dissatisfied patients who, on their return to the hospital, discredited the boarding home idea among their friends, so that many patients were unwilling to try to live in a private home. Miss Crockett

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1. Crockett, Ibid., page 199.

insists that in the long run it is cheaper to wait several months for the right place than to make a mistake on a difficult patient, since "the best of homes are not best for all patients."[1]

It has been generally found that schizophrenics make their best adjustment in a simple home situation. Depressed patients become more unhappy in a home where there are many people coming and going, creating excitement and confusion, but others may thrive in such an atmosphere. When family care was new, many patients were placed with those of their own social status since it was felt that they would be more apt to be accepted as members of the family. Miss Crockett's experience indicated that a patient could adjust to a lower level than that to which he had been accustomed, but attempts to improve the standards of some of the patients ended in failure. However, since 1934 experiments have proven that if the step up has been gradual and carefully planned that much success can be realized.

Sometimes a home that considers other matters of greater value than perfect order has its advantages. Patients who are very orderly become unhappy in homes that are indifferent on this point, whereas patients who are happy in disorder do not get along in homes that are always immaculate.

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1. Crockett, Ibid., page 199.

Patients may be fitted to each other as well as to the home. It has been found dangerous to add a patient of doubtful reactions to a happy and contented group. This has been avoided by the placing together of people of similar tastes.

D. SUPERVISION

Supervision is a vital part of the family care program. The law requires that a patient be visited at least once in three months.[1] It is now the policy of the social worker to visit each patient about once each month. The 1934 study revealed that 73 per cent of the patients were visited once per month and the remaining 17 per cent were visited less frequently up to the specifications of the law.[2]

When the social worker makes her supervisory visit, she first interviews the caretaker alone. She finds out about the patient's condition, physical and mental, and about his activities within the home and outside. Any problems which have arisen or seem pending are discussed with the caretaker and advice is given on how to deal with them. There are further frequent contacts with the caretaker through the medium of telephone calls made because of acute problems or difficulties which cannot wait for the worker's visit.

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1. Annual Report of Board of Health, Lunacy and Charities, 1885.
2. Bentley, Ibid., page 13.

The contact with the patient is limited within certain areas. The worker listens to the complaints, ideas and requests which she discusses with the patient. She has the opportunity to observe the patient in his activities and relationships with the other patients and with members of the family group. This contact gives some indication of the progress of the patient and what steps he is making toward a more adequate social adjustment and complete recovery. Personal service plays a large part in the worker-patient relationship. Clothes are secured and delivered to the patients; social contacts are made with and for them; the patients are returned frequently by the worker to the hospital for medical and dental treatments; shopping is done with them, and on occasions trips are made with the patients for recreational purposes. These activities are an integral part of a function which tends to stimulate and help the patient to make the most satisfactory adjustment within his limitations. This purely routine activity consumes a large part of the worker's time and is a definite limitation on her many more professional functions.

Very little psychotherapy has been done with the patient in the family care homes. This is in accord with the present policy of the hospital concerning psychotherapy done with the family care patients. The emotional problems of the patient are not dealt with by the social worker because at

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present this is considered the function of the psychiatrist.

E. RECORDING

As important as the supervisory activity is in guiding the placements toward effectiveness for the patient, there is the equally important function of recording. It has been admitted by the social worker herself that much can be done to improve the family care records, in scope and content. The major barrier to more adequacy in record writing has been the time element and the multiplicity of activities which crowd the work-day of the social worker to the point that completeness in reporting all her activity is a difficult problem. In the past, the record writing was confined to reports of the worker's contacts on the supervisory visit to the family care home with a brief statement as to the patient's condition and progress. Also, reference was made to problems which arose during the interim between visits and how the problems were handled. When an attempt was made to enlist the cooperation of the patient's family and have them consider taking the patient on visit, a brief statement of the make-up and status of the family situation and a reflection of their attitudes toward the patient were recorded. The keynote of the recording was brevity and the reason again was the paucity of time.

With the trend toward the therapeutic use of the homes there came a recognition on the part of the social

worker that her records were inadequate. For some time attempts have been made to broaden and intensify the record. When interviewed the social worker expressed the hope that such a recording program will be the basis for future record writing activity, but it was pointed out that the determining factor in the success of this program will be the pressure of the work with a limited personnel. The broadened program for recording would include:

1. A picture of the personality of the patient as he is in the hospital before placement; a statement about his adjustment, his needs and his prognosis for the future. Also recorded should be the plan for placing the patient and effecting his social rehabilitation.

2. The patient's family situation is to be outlined with its attitudes toward the patient and his illness, their status, availability and feelings about taking the patient on visit, plus any changes in these family conditions.

3. A detailed account of the actual contacts with the patient, from the initial contact with him through the process of placing him, in his adjusting efforts in the home, and finally during his removal from family care to the community or back to the hospital. This section of the record should include the contacts of the patient with the caretaker and family, the feelings of the patient about his placement, the problems arising out of the placement, and their effect

on the patient. This should be a charting of the progress of the patient from the convalescent stage either to that of reestablishment in his own community or to the return to the hospital with a statement of the reasons for the failure of the placement.

F. SOCIAL REHABILITATION

In no instance is a patient, who is capable of social adjustment, allowed to feel that family care is the final solution of his problem. Every effort is made to get the patient back to status in the community. The staff physician visits each patient in family care once every three months. Following physical and mental examinations, and consultation with the social worker, he recommends to the hospital staff patients who should be released on visit or discharged.

An evaluation, at this time, of the inherent capacity of the patient to make this step is not enough. First, there should be developed in the patient the will to get better and to regain his former position as a member of his family and his community. He may be helped to face the difficult problems and ever-present barriers to a successful venture into the society from which he was removed usually under disagreeable circumstances. These difficulties can be faced long before the visit plan is proposed. The patient should attain confidence in himself and his ability to face this

social re-adjustment. He is forced to face the stigma which he will carry as an unfortunate burden. A second factor is the manipulation of the environment to the point where it can be favorably receptive to the patient.

The social worker has this rehabilitation as her goal throughout the patient's family care placement and she does all she can to prepare the patient and manipulate the environment so that the eventual discharge of the patient on visit may be effected.

The patient is interviewed on almost every visit with the emphasis on his interests and plans for the future. He is encouraged to make plans and to talk them over with his family and the worker. Every effort is made to have these plans realized. The patient is urged to seek employment especially if the visit plan is dependent upon such an achievement. The worker often makes vocational contacts with and for the patient. When a job is secured and the visit status approved by the staff, the worker aids the patient to find suitable living arrangements and is a constant source of support during the first few months of uncertainty and sometimes discouragement.

The second focus of attention in this process of rehabilitation is the patient's family. During the period of the patient's placement, the family is contacted by the worker to obtain money and clothing for the patient, and also to

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help prepare them for the return of the patient. In many cases the family is not in a position to take the patient, and the worker through her contacts often does much to increase the adequacy of the family and thus its availability as a place for the patient. Often the family is willing to accept one of its members from a boarding home, but has feared to remove him directly from the hospital. Before the return of the patient to the home there comes a period of orientation on the part of the family somewhat similar to that given the caretaker. The implications and nature of the patient's illness are outlined as is the relationship between family and patient, with precautions given as to attitudes and specific actions. The family is thus enlisted as an ally on the side of those who will attempt to make this re-adjustment by the patient a successful venture.

CONCLUSION AND RECOMMENDATIONS

The trend toward the therapeutic use of the family care home has brought with it a number of related problems which need serious consideration. The major problem seems to be in the administrative control and supervision of this program. With the growth of this therapeutic idea has come a clarification of objectives and a definition of approach toward achieving them. At the same time the functions and responsibilities of the guiding force behind this program, namely the social worker, have extended and are beginning to stand out as major factors in the continued development of family care.

The material accumulated in this study reveals that this trend has brought with it definite and specific emphases which reveal themselves as basic to the effectiveness of this work. The type of patient referred, together with the therapeutic purpose of the placement, has involved greater selectivity in finding homes. More time and skill is consumed in preparing the homes and the caretaker, for they represent the key to the success of the placement. More effort is now devoted to gaining an understanding of the needs of the patient and in the planning to meet these needs. Closer and more frequent supervision together with careful and more detailed recording are required. There is

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the stimulation of and the interpretation to the patient's family toward the assumption of its role in the therapeutic plan which follows, a function not stressed when the custodial placements were the major consideration. Finally, more active and intensive rehabilitative work with the patient is necessary in order to bridge the step to the community.

If these emphases represent, as they indicate, the re-interpreted and redefined function of the family care social worker, it is necessary to consider her ability, physical capacity as well as professional competence, to perform this activity. In a typical home placement agency, the social worker carries a maximum case load of 50 cases for the purpose of supervision. The function of home finding is carried by a separate worker. In comparison, the one family care social worker (up to September 1938) carried a case load of over 100 cases of which about 60 were treatment cases requiring the intensive work outlined above. Also she carried the burden of home finding. With the trend toward the referral of treatment cases and the supplanting of the custodial placements, we find that by January 1, 1939, there were 125 patients in family care of whom 82 were placed for therapeutic purposes. It therefore seems conclusive in its indications that the effectiveness of this program and the possibilities of its further growth as a therapeutic tool is, in the beginning at least, entirely dependent upon the

provision of an adequate personnel. This should include at least two full-time social workers devoting their efforts to family care alone, plus the provision of a third worker if the placements exceed 150.

Other points which may be considered as basic to greater effectiveness of the family care program are listed below:

1. The referring physician can be more thorough and definite in his statements of reasons for and recommendations with referrals.

2. Family care homes selected for therapeutic purposes would be more valuable if not used for custodial patients, for when once a home is used for a custodial patient the caretaker is no longer willing to assume the added responsibility characteristic of the other type of placement.

3. There could be still more contact by the worker with the patient's family in the attempt to gain its cooperation in taking patients on visit directly from family care.

4. There is a need for more recreational and occupational opportunities in the family care homes. This problem has been discussed with the Occupational Therapy Department and tentative plans have been drawn up which can be carried out if adequate personnel could be provided.

5. Many excellent applications to take family care patients have been withdrawn because of the inadequacy of the

payments made for state patients. This indicates a need for a more flexible scale which can be adjusted to correspond to the changes in the cost of living conditions.

In conclusion it can be stated that family care is still in its early stages of development, but the encouragement of the growth and the trend toward its therapeutic use indicates the place it may assume in the care of the mentally ill. The clinical director, under whose guidance this program has expanded to date, when interviewed made the following statement, "Family Care is the best therapeutic tool known to-day for the care of the convalescent patient."

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